THE HEALTH CARE FINANCING ADMINISTRATION

Medicare Part A Specification

for the

ANSI ASC X12 835 Version 003051

Implementation Guide Version 4A.01

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MEDICARE   PART   A
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Electronic Remittance Advice

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I.   INTRODUCTION

The Health Care Financing Administration (HCFA) has adopted the American
National Standards Institute (ANSI), Accredited Standards Committee (ASC) X12
Health Care Claim Payment Advice (835) as the standard format for the
electronic data interchange (EDI) of Medicare electronic remittance advice
(ERA) data and the electronic transfer of payment for Medicare services.

A.   Purpose of Implementation Guide 4A.01

This implementation guide is intended to provide assistance in the development
and execution of the electronic transfer of remittance advice data and/or
payment. As adopted for use by Medicare Part A, all specifications in this
document conform to ANSI ASC X12 835 standards forVersion 003, Release 05,
Subrelease 1 (V003051). These specification are designed to be compatible
with the communications networks of financial institutions.

B.   Scope and Applicability

The purpose of this implementation of these standards is to expedite HCFA's
goal of achieving a totally paperless claims processing and payment
environment. The ANSI ASC X12 standards are formulated to minimize the need
for users to reprogram their data processing systems for multiple formats by
allowing data interchange through the use of a common interchange structure.
These standards do not define a method in which interchange partners should
establish the required electronic media communication link nor the hardware
and translation software requirements to exchange EDI data. Each intermediary
must provide these specific requirements separately.

This document does not address the specific requirements of non-Medicare
payers. If providers choose to utilize 835 to exchange remittance data or
electronic funds transfer (EFT) with other payers, they must contact the
payers directly for their requirements.

II.   BACKGROUND

A.   Electronic Data Interchange (EDI)

EDI is the acronym for Electronic Data Interchange. EDI is the exchange of information via routine business transactions in a standardized computer format; for example, data interchange between a Medicare intermediary and a provider. EDI originated when a number of industries desired to save costs and reduce waste through the electronic transmission of business information. They were convinced that in this computerized world, standardization of formatted information was the most effective means of communicating with multiple trading partners.

EDI offers several advantages. In addition to standardized formats that can be used with multiple trading partners, technology now allows anyone with a computer and a modem to participate in EDI. With EDI, there is a substantial reduction in handling and processing time and the risk of lost paper documents is eliminated. However, as with any new technology, there are costs associated with EDI. These costs are likely to be similar to those incurred in any decision to automate, although with EDI new issues may have to be evaluated for the first time.

B.   ANSI and ASC X12

The American National Standards Institute (ANSI) coordinates voluntary standards in the United States. Many standards developers and participants support ANSI as the central body responsible for the identification of a single consistent set of voluntary standards called American National Standards. ANSI provides an open forum for all concerned interests to identify specific business needs, plan to meet those needs and agree on standards. ANSI itself does not develop standards. ANSI approval of standards indicates that the principles of openness and due process have been followed in the approval process and that a consensus of those participating in the approval process has been achieved.

In 1979, ANSI chartered a new committee, known as Accredited Standards Committee (ASC) X12, Electronic Data Interchange, to develop uniform standards for electronic interchange of business transactions. The work of ASC X12 is conducted primarily by a series of subcommittees and task groups whose major function is the development of new, and the maintenance of existing, EDI standards.

Currently, ASC X12 has more than 600 voluntary members. Membership is open to virtually all organizations and individuals with a material interest in the

standards. Benefits include an opportunity to vote on every issue before the
X12 committee and frequent information updates on committee activities and
standards. The insurance subcommittee of ASC X12 includes representatives
from health care payers, providers, provider associations, banks, software
vendors and government agencies (Medicare, Medicaid, etc.). If you would like
additional information on ANSI standards please contact the Data Interchange
Standards Association, Inc. at the address provided on page 5 of this
implementation guide.

C.   HCFA Use of X12 Standards

In the near future, X12 standards are anticipated to be the national norm for
electronic transmission of health care data. As part of HCFA's continuing
commitment to achieve administrative savings through the use of electronic
claim processing options, including the decision to migrate to financial EDI,
HCFA became a member of the X12 committee. HCFA's active participation in
X12 is expected to accelerate the acceptance of specific electronic standards
throughout the health care industry.

HCFA is committed to developing and maintaining claim and remittance advice
formats according to X12 standards for use by Medicare fiscal intermediaries
(FIs) and carriers. A version of the ANSI Health Care Claim Payment
Remittance Advice (835) has been offered by FIs since October 1992. An 835
for carriers, as well as a Health Care Claim (837) for both FIs and carriers
were implemented on October 1, 1993.

D.   Implementation Guide Changes

This implementation guide is specific to the Medicare Part A program and has
been developed within the standard for the ANSI ASC X12 835 transaction,
version 003051. All future changes to this implementation guide will remain
within the requirements of the X12 835 standard.

A principal objective of this 4A.01 Implementation Guide is to eliminate
variations which exist in the Medicare Part A 835 remittances which are
returned to providers by different Medicare intermediaries. To this end the
optional usage of segments and data elements has been eliminated in this
implementation guide. All segments and data elements are either mandatory,
conditional or not used. Within the Implementation Detail, the word
'mandatory' means that this segment or data element must be written. The word
'conditional' means that if the associated data is present in the bill
processing system it must be returned in the 835. Appendix D provides a
comprehensive list of the significant changes between Medicare's 3A.00
Implementation Guide and the 4A.01 Implementation Guide.   Appendix E
provides a comprehensive list of the significant changes between the 4A.00

Implementation Guide and this 4A.01 Implementation Guide.

Implementation guide updates for Medicare will continue to be released through HCFA until the first health care industry wide implementation guides are released as a result of the Health Insurance Portability and Accountability Act (HIPAA). ASC X12 subcommittees and task groups continue to develop and maintain EDI standards. To meet legislative and regulatory requirements, HCFA will participate with X12 to revise the standards as necessary to meet industry needs.

Revisions of HCFA implementation guides for the ANSI ASC X12 transactions are anticipated to be released on an annual basis only if necessary to accommodate additional HCFA or provider business needs. At times HCFA may need to revise the way Medicare Part A uses existing standards. In the event of such situations, HCFA will make copies of the revisions to its implementation guides available to all interested parties.

   E.   Electronic Funds Transfer (EFT)

The Abbreviated 835

There may be situations when an 835 transaction set is used to notify banks that payment is being sent through banking networks without remittance information, i.e., EFT only. In such cases, an abbreviated 835 can be sent. The abbreviated 835 and envelope would include the following segments, which must be used in this sequence:

     0-010-ISA, 0-020-GS, 1-010-ST, 1-020-BPR, 1-040-TRN, 1-060-REF,
     1-080.A-N1, 1-080.B-N1, 3-020-SE, 4-010-GE, and 4-020-IEA.

An option exists to send other segments from Table 1 in proper sequence, such as 1-100-N3 or 1-110-N4 after 1-080-N1. Table 2 information or the PLB segment from Table 3 would not be transmitted in an abbreviated 835.

It is important to ensure that a FI obtains all the necessary data from all banks participating in an EFT transaction. This additional data must be in the intermediary file for the provider receiving the EFT and should be properly reflected in every BPR segment each time an EFT is sent. For example:

Data Element	EFT Requirement
BPR01	Select 'D' = 'Payment only';
BPR04	DO NOT Select 'CHK' = 'Paper check.'

BPR has a total of 16 data elements. Data elements 01-04 and 16 are required whenever an 835 is sent by a FI. However, BPR05-10 and BPR12-15 are specifically applicable to an EFT and/or remittance information being sent

through financial institutions.

HCFA Policy

HCFA is committed to offering all Medicare providers the option of receiving
payments and remittance advices electronically. Providers are encouraged to
contact their FIs for additional information regarding Medicare's electronic
payment environment.

Medicare's commitment to EFT/ERA will offer several advantages to FIs and
providers. Advantages for FIs include: the reduction of administrative
expenses associated with the generation of checks and hard copy remittances,
the certainty of delivery of payment and the elimination of the need to mail
checks and remittances. For providers, advantages include: better cash
management forecasting, timely delivery of payment and remittance information,
elimination of the burden associated with depositing checks and reduction of
clerical costs for account reconciliation. 835 data may be also sent through
the banking network at a provider's request as long as beneficiary-specific
data are not viewed or manipulated in the process.

FIs will effectuate provider EFTs through the Automated Clearing House (ACH).
The ACH was designed as a computer-based alternative to the existing check
clearance system. The ACH facilitates the collection and settlement of
check-like payments. Over 10,000 financial institutions in the United States
are ACH members. For EFT, HCFA FIs will only cover the cost of transmission
of the EFT through their banks to the ACH.

III.   THE MEDICARE PART A 835 TRANSACTION SET

        A.   INTRODUCTION TO THE 835

This section provides information for the actual use of the 835 by Medicare
intermediaries to transfer remittance information or payments to a provider
electronically. This implementation is based upon the X12 Standards Draft
Version 003, Release 05, Subrelease 1 (V003051). A copy of the standards
document is available through:

                Data Interchange Standards Association, Inc.
                1800 Diagonal Road, Suite 200
                Alexandria, Virginia 22314-2852
                (703) 548-7005

        B.   835 PHILOSOPHY

The ANSI ASC X12 835 DSTU (draft standard for trial use) presents the format
and establishes the data contained in the "Health Care Claim Payment/Advice"
transaction set within the context of the EDI environment. This 835 is
intended to be used by payers, providers and their respective banks to make a
payment, send a remittance advice to explain a Medicare payment or perform
both functions. In at least one medical specialty, dentistry, the 835 is also

used to give pre-authorization for payment prior to the delivery of services.

On the whole, however, the 835 is used to transmit payment and data needed for posting subsequent to adjudication of a claim. Medicare uses the 835 exclusively to transmit payments and information needed for posting, including reporting denials of claims and claims that contain a zero payment amount.

C.   835 BALANCING

Basics of Balancing the ANSI X12 835 Remittance Advice

The concept of balancing is essential to assuring uniform implementation of the 835 among ALL health care payers. In short, balancing means for every Version 003051 X12 835 implementation:

> At the line/service and claim level of remittance detail, when data is present, the difference of all billed/submitted charges and the net of all financial adjustments MUST equal the given payment amount at that level. Net claim and line/service level adjustments are subtracted from the claim submitted charges in order to equal the claim payment amount.

There are distinct locations for the subtotals of all billed/submitted charges and payment at these two detail levels:

> Billed/Submitted Charges:
>
> >   Line   Element SVC02 in the SVC Segment in the
> >   SVC Loop in Table 2
> >   Claim   Element CLP03 in the CLP Segment in the
> >   CLP Loop in Table 2
>
> Payment Amount:
>
> >   Line   Element SVC03 in the SVC Segment in the
> >   SVC Loop in Table 2.
> >   Claim   Element CLP04 in the CLP Segment in the
> >   CLP Loop in Table 2.

There are three detail levels where financial adjustments are present and must balance: line, claim and provider. These adjustments are placed in three distinct locations in the 835:

> >   Line   CAS Segment(s) in the SVC Loop in Table 2
>
> >   Claim   CAS Segment(s) in the CLP Loop in Table 2
>
> >   Provider   PLB Segment(s) in Table 3

The balancing routine aggregates financial information up from the line/service level, to the claim level and then to the provider/transaction

level in order to equal a SINGLE payment amount in Element 02, BPR Segment, Table 1 for a SINGLE 835 transmission. Because the balancing routine makes calculations on all numeric data carried in the CAS and PLB adjustment segments no purely informational data is carried in the CAS and PLB adjustment segments.

The numeric value for total provider payment in element BPR02 cannot be less than zero. There are, however, situations where the total claim payment and provider level adjustments would be less than zero unless a counterbalancing adjustment is introduced to bring the transaction total to zero. In such situations, the PLB adjustment code 'BF' is used to indicate a negative balance amount which is used to balance the current transaction to zero and which will be carried forward and applied in a subsequent payment cycle. Since all numeric values occurring in adjustment segments are considered to be negative in value, the numeric string of a monetary amount element following the 'BF' adjustment code will be preceded by a minus sign in order to balance the 835. When received providers must retain the 'BF' coded negative balance amount in their accounting systems until it has been disbursed in subsequent 835 remittance cycles.

Situations will occur when a negative balance amount is not entirely disbursed in a single subsequent payment cycle. In these situations the 835 does not provide explicit notification to providers of the negative balance amounts which will be carried forward to subsequent payment cycles. Providers are expected to calculate the negative balance amounts to be carried forward in their accounting systems by subtracting the negative balance amount applied in the current 835, identified by a 'CO' adjustment code, from total outstanding negative balance amount(s) identified in previously received PLB segments with 'BF' coded monetary amounts. Since 'CO' coded monetary amount elements are used to identify the amount of outstanding negative balances applied in the current 835, no sign is used in the monetary amount element numeric string because positive numeric values in the CAS and PLB adjustment segments are SUBTRACTED from any positive numeric value calculated from the total claim payments, i.e., CLP04(s), and PLB adjustments in the providers favor, i.e., those, excluding 'BFs', which carry a negative sign in a monetary amount element.

Medicare Net Reimbursement

For the Medicare 4A.01 implementation of the 835, per claim net reimbursement will equal total payment excluding any interest which may have been paid by a Medicare contractor to a provider when the processing of "clean" Medicare claims exceeds certain time frames set forth in law.**CLP04 IS TO BE USED SOLELY TO EXPRESS MEDICARE NET REIMBURSEMENT FOR A CLAIM. It is ONLY in the PLB segment that interest paid to providers will be taken into account for financial balancing of the 835.** Medicare Part A interest payments will be effected through the following steps:

1.   Adjustment reason code "85" is NEVER to be used in CAS segments under

group code "OA" in Medicare-compliant 835 transmissions to express interest paid to providers when the processing of "clean" Medicare claims has exceeded certain time frames set forth in law.

2.   The per-claim interest amount, when present, will be provided in a claim-level AMT segment 2-062-AMT02 (CLP Loop). Since AMT segments are not part of the 835 balancing routine, these amounts are informational only and do not enter into the total payment at the claim level (Element CLP04).

3.   The total interest paid to a provider for an entire 835 transmission (under the circumstances described in 1. above) will be provided in a monetary amount element in the provider level adjustment PLB segment (PLB04/06/08/10/12/14). The PLB reference number elements (PLB03/05/07/09/11/13) preceding each monetary amount representing interest will begin with the provider level adjustment code "IN".

Formulas for Balancing

The following formulas depict the balancing algorithms for the 835 used through the health care industry.

Balancing with Line Level Data

1. SVC03 = SVC02 - (sum of all line level CAS03/06/09/12/15/18)

2. CLP04 = CLP03 - (sum of all line AND claim level
                    CAS03/06/09/12/15/18)

3. BPR02 = (sum of all CLP04) - (sum of all PLB04/06/08/10/12/14)

Balancing in the Absence of Line Level Data

1. CLP04 = CLP03 - (sum of all claim level CAS03/06/09/12/15/18)

2. BPR02 = (sum of all CLP04) - (sum of all PLB04/06/08/10/12/14)

**Note: Adjustments occurring at the line level must not be repeated
         at the claim level.**

Negative Reimbursement

In Medicare there are situations when a beneficiary's deductible and/or coinsurance amounts exceed the allowed payment amount. In such negative reimbursement situations CLP04 will reflect a negative amount. Because the total payment to the provider in BPR02 cannot be less than zero, balancing must be accurate and adjustments must be reflected in the CAS segments to account for the negative value in CLP04. In cases where there are no other claims with positive payment amounts against which to offset the negative reimbursement claim(s) in the 835, the PLB segment must be used to carry the negative balance forward to the next payment cycle. Use the provider level adjustment code 'BF' and a negative value amount adequate to balancing the 835 provider payment BPR02 to zero. In a subsequent 835, use PLB adjustment reason code "CO" to indicate the amount of outstanding negative balance which is being applied in the current 835.

Note: Negative amounts in CLP04 can also occur is situations of corrections and reversals. See Section D of this part of the implementation guide for instructions on corrections and reversals.

Arithmetic Signs in Adjustment Segments

In an 835 transmission, financial adjustments, if present, must be transmitted in either the line or claim level CAS segment or the PLB segment. It is important to remember that POSITIVE amounts in adjustment segments represent REDUCTIONS to payments, and NEGATIVE amounts represent INCREASES to payments. (For all segments other than adjustment segments, the arithmetic value of numeric amount elements is the value represented.)

The following examples are intended to aid in the balancing of HCFA's implementation of the Part A 835, release 3051. When present, each provider adjustment reason code value is paired with a monetary amount in the CAS and/or PLB segments. For simplicity, only PLB adjustments are represented in the following examples.

Note: PLB code messages are listed and described at the end of Appendix B.

EXAMPLE 1:   A PIP facility has PIP and non-PIP claim activity, plus PIP and
                 pass-through payments.

Data Element Description	Monetary Amount	Balancing Value of AMT String
Claims payment (sum of CLP04s)	50,000	+
PLB Adjustments		
PIP payment (PLB provider level adjustment code 'PP')	-100,000	+
PIP claims processed (PLB provider level adjustment code 'PA')	30,000	-
GME pass-through payment (PLB provider level adjustment code 'GM')	-1,000	+
Bad debt pass-through (PLB provider level adjustment code 'BD')	-1,000	+
Organ acquisition pass-through (PLB provider level adjustment code 'KA')	-1,000	+
Total Payment for this 835 (BPR02):	$ 123,000	+

EXAMPLE 2:   A Part A facility has claims activity, a credit balance refund,
                 and an offset for settlement of a subprovider.

Data Element Description	Monetary Amount	Balancing Value of AMT String
Claims payment (sum of CLP04s)	50,000	+
PLB Adjustments		
Provider refund adjustment (PLB provider level adjustment code 'PR')	-25,000	+
Offset from affiliate (PLB provider level adjustment code 'OA')	40,000	-
Total Payment for this 835 (BPR02):	$ 35,000	+

EXAMPLE 3:

CYCLE 1   The adjustment cycle resulted in a negative total claim payment
               $150,000.00. The resulting ERA balanced using the carryover
               amount to offset the claim total amount as follows:

Data Element Description	Monetary Amount	Balancing Value of AMT String
Claims payment (sum of CLP04s)	-150,000	-
PLB Adjustments		
Balance forward (PLB provider	-150,000	+

level adjustment code 'BF')

Total Payment for this 835 (BPR02): $ 0

CYCLE 2   Bills are received for a net payment of $80,000. This net payment
               amount is applied against the previous negative balance carryover
               amount of $150,000 leaving a negative balance of $70,000 to be
               carried forward to the next payment cycle in both the provider and
               payor accounting systems. The 'CO' code will be used in the PLB
               segment to indicate the amount of carried forward negative balance
               which is disbursed in the current 835 either to bring provider
               payment in BPR02 to zero or to reduce total CLP04 claim level
               payments by an amount which disburses the provider's total
               outstanding negative balance.

| | Monetary | Balancing Value |
Data Element Description	Amount	of AMT String
Claims payment (sum of CLP04s)	80,000	+
PLB Adjustments		
Carry-over negative balance applied (PLB	80,000	–
provider level adjustment code 'CO')		

Total Payment for this 835 (BPR02): $ 0

CYCLE 3   This cycle processed claims with adjustments which resulted in a
               negative total claim payment of $16,000.00. This negative claim
               payment amount requires a PLB monetary amount element string of –
               16000 with a 'BF' code value to balance the BPR02 element to zero
               and to indicate the establishment of a new negative balance to be
               carried forward and added to any existing provider level negative
               balances. Both payor and provider accounting systems must combine
               this new negative balance with any outstanding negative balances
               and record a total negative balance for this provider/payor
               respectively. In our current example, the $16,000 negative
               balance established in the current 835 must be added to the
               carried forward $70,000 negative balance for a new total negative
               balance of $86,000.

| | Monetary | Balancing Value |
Data Element Description	Amount	of AMT String
Claims payment (sum of CLP04s)	-16,000	–
PLB Adjustments		
Current cycle negative balance (PLB provider	-16,000	+
level adjustment code value 'BF')		

Total Payment for this 835 (BPR02): $ 0

CYCLE 4   This claim cycle results in a total claim payment of $170,000.00.

	Monetary	Balancing Value
Data Element Description	Amount	of AMT String
Claims payment (sum of CLP04s)	170,000	+
PLB Adjustments		
Carry-over negative balance applied (PLB	86,000	–
provider level adjustment code 'CO')		
Total Payment for this 835 (BPR02): $	84,000	+

EXAMPLE 4: A Part A provider has bill activity resulting in a CLP02 claim
payment amount of $100,000. However, this provider has a cost
report final settlement indicating a $150,000 overpayment which
requires a negative PLB amount of $50,000 to balance the BPR to
zero. Since this provider also has an outstanding negative
balance from a previous payment cycle of $50,000, the provider's
total negative balance to be carried forward in the provider's and
payer's accounting systems from cycle 1 to cycle 2 will be
$100,000.

CYCLE 1

	Monetary	Balancing Value
Data Element Description	Amount	of AMT String
Claims payment (sum of CLP04s)	100,000	+
PLB Adjustments		
Final Settlement (PLB provider	150,000	–
level adjustment code 'FS')		
Current cycle negative balance (PLB	-50,000	+
provider level adjustment code 'BF')		
Total Payment for this 835 (BPR02): $	0	

CYCLE 2   The payor's system applies $25,000 of the total outstanding
negative balance amount of $100,000 against the $25,000 CLP04
cycle 2 claim payment leaving a negative balance of $75,000 to be
carried forward into the next payment cycle by the payor and
provider.

	Monetary	Balancing Value
Data Element Description	Amount	of AMT String
Claims payment (sum of CLP04s)	25,000	+
PLB Adjustments		
Carry-over negative balance applied (PLB	25,000	–
provider level adjustment code 'CO')		

Total Payment for this 835 (BPR02): $ 0

CYCLE 3   Provider submits claims for a net payment amount of $50,000.
               Provider also receives a $70,000 PIP payment. The entire
               outstanding negative balance of $75,000 is applied against the
               total of the claim payment and PIP payment yielding a BPR02
               provider payment of $45,000.

	Monetary	Sign Value of
Data Element Description	Amount	Amount String
Claims payment (sum of CLP04s)	50,000	+
PLB Adjustments		
PIP payment (PLB provider level	-70,000	+
adjustment code 'PP')		
Carry-over negative balance applied (PLB	75,000	-
provider level adjustment code 'CO')		
Total Payment for this 835 (BPR02):	$ 45,000	+

Medicare Secondary Payer (MSP) Adjustment Calculation

In order to show patient liability and provider liability on a remittance
advice when MSP applies, intermediaries follow four steps to determine the
amount of Medicare payment when another payer is primary to Medicare:

    1.   Subtract the primary payment from the lower of the billed amount
      or the amount a provider is obliged to accept in full (OTAF amount
      which applies under a Workers Compensation or liability cap or in
      a managed care arrangement.)

    2.   Subtract any outstanding Medicare deductible from the Medicare
      allowed amount for the services on the claim. Multiply the result
      by 80%.

    3.   Subtract the primary insurer's payment from the greater of the
      primary payer's allowed amount or the Medicare allowed amount.

    4.   Pay the lesser of the amount in 1, 2 or 3.

If there are two or more payers primary to Medicare the 835 will provide only
one primary payment amount in the claim or line level CAS segment with reason
code 71 to reflect the total of primary payments used to offset the billed
amount when determining the Medicare payment. The MSP value code will be
reported in the MIA and MOA segments with remark codes for each payer primary
to Medicare.

Provider Adjustment Segment Theory

The PLB segment is designed to convey provider level adjustments that do not pertain to any given claim or service within the transmitted 835 transaction. The PLB and the CAS adjustment segments will carry only data which is used in the balancing calculations of the 835. These adjustment segments must not be used to carry data for informational purposes.

D.   REVERSALS AND CORRECTIONS

In cases where a claim has been paid in error, the Medicare method for error correction of a claim which has been processed and paid is to reverse the original claim payment and resend the corrected data. This reversal and correction method will assist providers in controlling the accuracy and integrity of their receivables systems.

Example of Reversal:

In the original 835 the reported charges, adjustments and payment amount were:

Submitted charges	$100.00
Disallowed amount	$-20.00
Coinsurance	$-16.00
Deductible	$-24.00

Incorrect Payment	$ 40.00

Original 835 for incorrect payment:

```
CLP*1234567890*1*100*40**MA*9602M1234567*13*1*01~
CAS*PR*1*24**2*16~
CAS*CO*45*20~
```

The payer found an error in the original adjudication of the claim that required a correction. In this case, the disallowed amount should have been $40.00 instead of the original $20.00, the coinsurance amount should have been $12.00 instead of $16.00 and the deductible amount remained the same, i.e.:

Submitted charges	$100.00
Corrected Disallowed amount	$-40.00
Corrected Coinsurance amount	$-12.00
Deductible amount	$-24.00

Corrected Payment amount	$ 24.00

Medicare Reversal Method

The Medicare reversal method is to reverse the original payment, restoring the patient accounting system to the pre-posting balance for this patient. Then, the corrected claim payment is sent to the provider for posting to the account. It is anticipated that the provider will have the ability to post these reversals electronically without any human intervention.

Reversal of the original claim payment is accomplished with a CLP02 value of "22", Reversal of Previous Payment, and appropriate adjustments in a CAS segment with an adjustment group code of CR, Correction. All original charge,

payment and adjustment amounts are negated.

CLP*1234567890*22*-100*-40**MA*9602M1234567*13*1*01~
CAS*CR*1*-24**2*-16**45*-20~

The corrected claim payment is provided as if it was the original payment.

CLP*1234567890*1*100*24**MA*9602M1234567*13*1*01~
CAS*PR*1*24**2*12~
CAS*CO*45*40~

NOTES:
1. **The reversal does not contain any patient responsibility amounts.**
2. **The above method must not cause the total payment amount to become negative.**
3. **The above example does not provide service line detail. If there was service line detail on the original payment, then the reversal should apply the same reversal logic to the claim and service levels.**

E.   MEDICARE A 835 IMPLEMENTATION GUIDE ORGANIZATION AND USE

The Implementation Set and Detail form the core of the 835 implementation guide for intermediaries. They represent a national standard. Intermediaries and their providers must follow these instructions when implementing the 835 for use in the Medicare Part A Program. No part of this text is to be modified without the knowledge and consent of HCFA.

In many cases, Medicare requirements are more specific than those of X12. In this implementation guide differences between the X12 specifications and HCFA's implementation guide are highlighted by boldface type. Boldface text represents HCFA's requirements for the X12 835 for the Medicare program. The Medicare requirements presented in boldface may represent a range of HCFA decisions, including standing Medicare policies to limit code choices to those appropriate to Medicare Part A. Nevertheless, the more specific requirements of Medicare articulated in this implementation guide are fully compliant with X12's specifications for the 835, Version 003051.

Implementation Guide Format

HCFA's Version 4A.01 Implementation Guide was designed to provide all technical information required for each segment in one section. This avoids having to move to other sections to obtain data element number, attributes, etc. The following describes how to read the implementation tables and detail.

IMPLEMENTATION SET

The Implementation Set is an overview of the entire 835 transaction as used in the Medicare Part A implementation guide. The transaction is divided into five tables numbered 0 to 4. Tables 0 and 4 are not actually part of the 835 transaction. They represent the opening and closing "envelopes" that enclose X12 transaction sets (the 835, 837, etc.). Table 1 opens the 835 and provides information on the sender, receiver and payee (Loop N1) of the 835, as well as their banks, version numbers and other things the sender and receiver need to share to transmit the 835 successfully.

Table 2 provides claim level information on the payment being described in the 835 being sent in the claim level CLP loop and on the service level in the SVC loop. [Loops link segments that share some commonality, e.g., they work to identify a payee, provide claim level data, etc.] The LX loop facilitates the repetition of segments at claim level and service level within Table 2. There will be at least one LX loop even when there is no fiscal period/bill type control break, unless the 835 is being used to transmit provider level adjustment information from a processing cycle where no claim data is present, as sometimes occurs with PIP payments and cost report adjustment data. Table 3 gives information on provider level adjustments and closes the 835

transaction. A sample of the columns and their contents from Table 2 is reviewed below.

TABLE 2

Nte	Pos.	Seg. Name			Req.	Max.Use	Loop Repeat
		LOOP ID - CLP [1]					>1 [2]
	010	CLP	Claim Level Data		M	1	
N	020.A	**CAS**	**Claim Level Adjustments**		M	99	
[3]	[4]	[5]	[6]		[7]	[8]	

where:

[1]   The "Loop ID" identifies the loop in which related
       segments are grouped.

[2]   The number of times the loop can be repeated.

[3]   Notes ("Nte") follow the table specifying relational
       conditions, general explanation, etc.

[4]   "Pos." gives sequential position number for the segment
       within the 835 based on the ANSI ASC X12 835 positions.

[5]   Under the first part of "Seg. Name", the official ANSI
       ASC X12 acronym for each segment used in the 835 is
       given.

[6]   The name of each segment used in the Medicare Part A
       implementation of the 835 is given in the second part of
       "Seg. Name".

[7]   "Req." is requirement designator, and gives a letter indication
       the requirement status for each segment:
            M = Mandatory or C = Conditional. N is not really a
            requirement status, but instead stands for "not used,"
            which means this particular segment is not used for Medicare
            Part A implementation of the ANSI ASC X12 835 transaction
            set.

[8]   "Max. Use" gives the maximum number of times each segment can be
       used in an 835. Most of these entries are 1 or greater than
       (>) 1.

IMPLEMENTATION DETAIL

The Implementation Detail reiterates and supplements information contained in the Implementation Set. The columns and their contents are described below.

Medicare B 835 Health Care Claim/Payment Advice   2-010-CLP [1]

                              [2]
X12 Segment Name: **CLP** Claim Level Data
          Loop: CLP   Repeat >1
      Max. Use: 1
   X12 Purpose: To supply information common to all services of
                a claim
         Usage: **Mandatory**
       Example: **CLP*76543SMITH*1*500*200*100**96O2Ml234567~**
      Comments: **This is the first segment written for each
                claim.**

    Semantic Note: CLP03 is the amount of submitted charges this   **[3]**
                          claim.
    Semantic Note: CLP04 is the amount paid this claim.
    Semantic Note: CLPO5 is the patient responsibility amount.
    Semantic Note: CLP07 is the payer's internal control number.
    Semantic Note: CLP12 is the diagnosis-related group (DRG) weight.

  Element
Attributes   Data Element Usage   **Flat File Map**

CLP01 1028   Claim Submitter's Identifier   **20-05   [6]**
AN 1 38 M   **Patient Control Number   [5]**
   [4]   Identifier used to track a claim from
                  creation by the health care provider
                  through payment.
                  **Claim identifier originally assigned by
                  the provider. It is carried through the
                  payor's system and returned to the
                  provider to allow account posting. If
                  the Patient Control Number is not
                  submitted on the incoming claim, enter a
                  zero in this element.   [7]**

where:
     [1]   The page header referencing the implementation of the transaction
            to the left and the table and segment position (2-010) and the
            segment identifier (CLP) to the right.
     [2]   The header for the segment itself, appearing at the beginning of
            each segment. Medicare specific information is bolded. However,
            ANSI ASC X12 information is not overwritten, so that if the X12

name differs from the Medicare name of the segment, two name lines will appear, the first being "X12 Name", the second being "Industry Name" is bold. The purpose can also be repeated in this same fashion if the Medicare purpose is more specific than the "X12 purpose". "Loop", "Max. Use" and "Usage" (requirement status) have already been presented in the Set. The "Example" shows how the segment might look when received before translation. It is important to note that these examples have intentionally been kept simple and easy to understand and, therefore, may not be complete illustrations of what would have to be transmitted in any given segment to adhere to Medicare Part A requirements. "Comments" provide additional insight into the use of this segment.

[3] "Semantic Note(s)" highlight the meaning of particular elements within the segment.

[4] "Element Attributes" again present characteristics of each element where:

      CLP01 is the data element reference designator;
      1028 is the X12 data element dictionary reference #;
      AN   is the data element type;
      1   is the minimum data element length;
      38   is the maximum data element length;
      M   is the requirement designator.

[5] "Data Element Usage" begins by giving the X12 and, if different, Medicare Part A name for a given element.

[6] In the "Flat File Map", the flat file fields which correspond to the data elements of this 835 implementation are listed.

[7] Also under "Data Element Usage" appears the X12 definition of the element, and, if different, the Medicare definition follows in bold. In some cases, such as CLP02, code lists may be included in the definition under "Data Element Usage" if needed to fill the element. In other cases, if a code list is necessary but too long to reproduce within a given segment, it is referenced in the text. Unfamiliar code lists, unlike the common HCPCS procedure codes, which providers may not have immediate access to are given in appendices if they are too long to fit within a segment.

Additional Information on Delimiters and Acknowledgments

Delimiters

ASC X12 standards allow for the usage of various characters as delimiters. The actual delimiters used in any specific interchange are determined in the envelope, specifically within the ISA segment. The ISA segment consists of all mandatory data elements, with fixed data length, i.e. the minimum and maximum are identical.

The data element separator and segment terminator used in the ISA determines the characters used throughout the entire data interchange defined by that ISA and its corresponding trailer segment, the IEA.

In the balance of this Version 4A.01 implementation Guide, the "*" is shown as the data element separator, ">" is shown as the subelement separator and "~" is shown as the segment terminator.

Functional Acknowledgments

The Medicare Part A implementation of the 835 will not utilize the X12 Functional Acknowledgment capability, since HCFA does not believe providers should be obligated to acknowledge receipt of each 835 to the sending intermediary. Therefore, Element ISA14 always contains "0" and the TA1 is not supported. This does not preclude the use of the functional acknowledgment with other transactions.

However, every intermediary and provider (sender and receiver) may choose to make an agreement of their own regarding functional acknowledgments. The ANSI ASC X12 997 transaction set has been designed to allow pairs of senders and receivers ("trading partners") to establish a comprehensive control function as part of their business exchange process. This acknowledgment process between trading partners facilitates control of multiple interchanges (batches) amongst multiple pairs of trading partners. There are many EDI implementations that have incorporated the acknowledgment process, for control purposes, in all of their electronic communications. Medicare intermediaries must accept and process 997's if a provider chooses to send them. However, intermediaries may not require providers to submit 997's.

The 997 transaction is typically utilized as a functional acknowledgment to a previously transmitted interchange. Many translators can automatically generate this transaction set through parameter settings. Additionally, translators will automatically reconcile acknowledgments to interchanges. The benefit to this process is that the sending trading partner (in this case, the intermediary) can determine if the receiving trading partner (the provider or designated agent) has received the 835 through reports that can be generated by the translator software to depict interchanges that have not been acknowledged.

As with any information flow, an acknowledgment process can be essential. If
an "automatic" acknowledgment process is desired between trading partners,
then the 997 is recommended.

F.   Implementation Set for the 835 Health Care Claim Payment Advice

This Draft Standard for Trial Use contains the format and establishes the data contents of the Health Care Claim Payment/Advice Transaction Set (835) within the context of the Electronic Data Interchange (EDI) environment. This transaction set can be used to make a payment, send an Explanation of Benefits (EOB) remittance advice, or make a payment and send an EOB remittance advice only from a health insurer to a health care provider either directly or via a financial institution.

		TABLE 0					
Nte	Pos.	Seg.	Name	Req.	Max.Use	Loop	Repeat
	010	ISA	Interchange Control Header	M	1		
	020	GS	Functional Group Header	M	1		

		TABLE 1					
Nte	Pos.	Seg.	Name	Req.	Max.Use	Loop	Repeat
	010	ST	Transaction Set Header	M	1		
	020	BPR	Beginning Segment for Payment Order	M	1		
	030	NTE	-	**N**	**0**		
C	040	TRN	Trace	**M**	1		
C	050	CUR	**-**	**N**	**0**		
	060	REF	**Implementation Guide Version Code**	**M**	1		
	070	DTM	**Payer Cycle Date**	**M**	1		
			LOOP ID - N1				2
C	080.A	N1	**Payer Name**	**M**	1		
C	080.B	N1	**Payee Identification**	**M**	1		
	090	N2		**N**	**0**		
	100	N3	Address Information	C	1		
	110	N4	Geographic Location	C	1		
	120	REF	-	**N**	**0**		
	130	PER	-	**N**	**0**		

<table>
<tr><td colspan="7" align="center">**TABLE 2**</td></tr>
</table>

Nte	Pos.	Seg.	Name	Req.	Max.Use	Loop Repeat
			LOOP ID - LX			>1
N	003	LX	**Loop Indicator**	**C**	1	
	005	TS3	**Transaction Statistics**	**C**	1	
	007	TS2	**Inpatient PPS Statistics**	**C**	1	
			LOOP ID - CLP			>1
	010	CLP	Claim Level Data	M	1	
N	020	CAS	**Claim-Level Adjustments**	M	99	
	030.A	NM1	**Patient Name/Number**	M	1	
	030.B	NM1	**Crossed Over/Transferred**	**C**	1	
	033	MIA	Medicare Inpatient Adjudication	**C**	1	
	035	MOA	Medicare Outpatient Adjudication	**C**	1	
	040	REF	**Provider Claim Identification**	**C**	1	
	050.A	DTM	**Beginning Service Date**	**M**	1	
	050.B	DTM	**Ending Service Date**	**M**	1	
	060	PER	-	**N**	**0**	
	062	AMT	Monetary Amount	C	8	
	064	QTY	Quantity	C	6	
			LOOP ID - SVC			999
	070	SVC	Service Information	**C**	1	
N	080	DTM	**Service Date**	**C**	**1**	
N	090	CAS	**Line level Adjustments**	**C**	99	
	100.A	REF	**ASC Group Number**	**C**	1	
	100.B	REF	**ASC Rate (percent)**	**C**	1	
	110.A	AMT	**ASC Priced Amount**	**C**	1	
	110.B	AMT	**Per Diem Amount**	**C**	1	
	110.C	AMT	**HHA Visits**	**C**	1	
	120	QTY	**Non-Covered Visits**	**C**	2	
	130	LQ	**Reference Line Level Remark Codes**	**C**	99	

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TABLE 3

</div>

Nte	Pos.	Seg.	Name	Req.	Max.Use	Loop Repeat
	010	PLB	**Provider-level Adjustments**	**C**	99	
	020	SE	Transaction Set Trailer	M	1	

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TABLE 4

</div>

Nte	Pos.	Seg.	Name	Req.	Max.Use	Loop Repeat
	010	GE	Functional Group Trailer	M	1	
	020	IEA	Interchange Control Trailer	M	1	

— —

Table 2 Position 003 Note 1:
     The LX segment is used to provide a looping structure and logical
     grouping of claim payment information.

Table 2 Position 020 Note 1:
     The CAS segment is used to reflect changes to amounts within Table
     2.

Table 2 Position 080 Note 1:
     The DTM segment in the SVC loop is to be used to express dates and
     date ranges specifically related to the service identified in the
     SVC segment.

Table 2 Position 090 Note 1:
     The CAS segment is used to reflect changes to amounts within Table
     2.

Table 1 Position 040 Comment 1:
     The TRN segment is used to uniquely identify a claim payment and
     advice.

Table 1 Position 050 Comment 1:
     The CUR segment does not initiate a foreign exchange transaction.

Table 1 Position 080 Comment 1:
     The N1 loop allows for name/address information for the payer and

payee which would be utilized to address remittance(s) for
delivery.